Texas Child Fatality Review Teams

1996-97 Biennial Report

Texas Child Fatality Review Team

acknowledgements

The production of this report mirrors the cooperative, multiagency efforts put forth by local child fatality review teams. Expert contributions have been made by many professionals for whom the Child Fatality Review Team state committee offer our heartfelt thanks and gratitude for producing this report

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foreword

The future of the State of Texas lies in the health and safety of our children today. Each year, 4,000 Texas children under the age of 18 die and many of these tragedies are preventable. In many cases, reviewing the circumstances surrounding the death can identify the true cause of death and provide lessons which can direct prevention initiatives. Realizing this, the 74th Texas Legislature created an organized approach for child fatality review.

The enabling legislation authorized both local child fatality review teams and a state committee charged with oversight and support. Local teams, made up of law enforcement, prosecutors, medical examiners, health care professionals, child advocates and protective service professionals, public and mental health experts and justices of the peace, review deaths in their jurisdiction for clues as to why the child died. These teams are uniquely qualified to understand what no single agency or group working alone can: how and why children are dying in their community. These multi-disciplinary multi-agency reviews of the circumstances surrounding a death can identify the true cause of death and may help identify prevention strategies. Local authorities can take the most appropriate action after a child's death is thoroughly investigated by the local team.

The State Committee collates information submitted by local teams and identifies barriers to effective child death investigations. They also provide assistance to local teams, help formulate standard investigation protocols for use by local authorities, and encourage the formation of new teams. The Texas Department of Protective and Regulatory Services, The Texas Department of Health, and the Children's Trust Fund Council of Texas were selected to facilitate activities in support of review teams throughout the state.

This report highlights the work of local teams throughout Texas and provides a capsular review of child death information for 1996 and 1997. By using this information, we hope that agency officials, child advocates, and concerned citizens will find new and innovative ways to reduce the tragic impact of the unnecessary death of Texas children. In the interest of child health and safety, and on behalf of the State Committee and the local Child Fatality Review Teams, I present this report for your information.

Dennis M. Perrotta, PhD, CIC
Chair, State Committee

preface

On July 7, 1998 our child fatality review team became aware of a 4 year old boy who drowned in our local lake while swimming with his 6 year old brother. When the boys' grandmother, who had taken them to the lake, told them to get out, the older boy came out of the water alone. He thought his brother had already returned to shore.

The Justice of the Peace who ruled the death accidental drowning did not refer the body for autopsy. Members of our newly formed team had just days before returned from the Child Fatality Review Team Network Meeting in San Antonio. The presiding officer used the newly acquired Child Fatality Review Team Investigation Procedures book to quote the law regarding autopsies for children under age 6 dying suddenly and unexpectedly to our local District Attorney. The DA contacted the JP and the autopsy was ordered.

The family was initially angry about the autopsy, but it was explained that perhaps the child had a previous condition which would explain him going under without any notice. An explanation of this sort could help the grandmother with the enormous guilt she had for not watching him closely enough.

Although nothing unusual was found, the child fatality review team was instrumental in assuring that the state law was followed and the death of this child was accurately recorded.

This is but one example of the effectiveness of local child fatality review teams in increasing the understanding of the nature and scope of child deaths in Texas. It is through the cooperative multiagency efforts of professionals volunteering their time and expertise that policy measures and in-

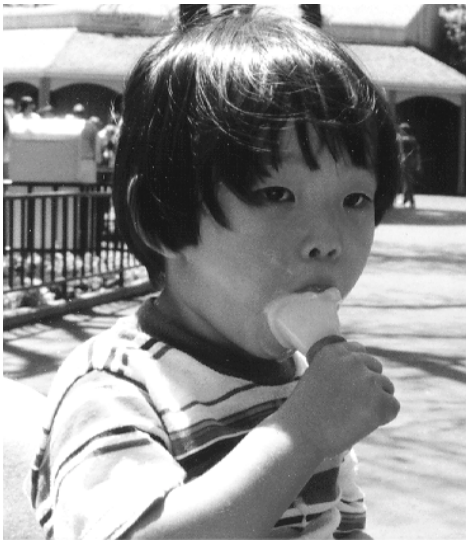
tervention efforts can be identified to help prevent the needless death of many Texas children.

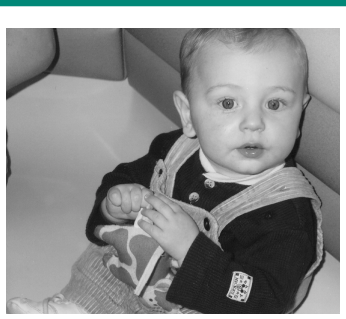
This book is designed to provide a simple understanding of the leading causes of child death and the role of child fatality review teams. Each of the case vignettes included in this report is taken from the reviews conducted by local teams. All identifying information has been changed in order to protect confidentiality.

The reader is encouraged to also refer to the companion book of this biennial report. The "Texas Child Fatality Review Teams 1996-1997 Biennial Report Data Book" contains tables, graphs, and charts providing comprehensive information about child deaths in Texas. The Data Book is also available at the Texas Child Fatality Review Team website: www.tdh.state.tx.us/epidemiology/cfrt.html

If you are interested in starting a review team in your area or want more information about child fatality review teams, please contact: Janece Keetch, Child Fatality Review Teams State Coordinator at (512) 438-4963.

table of contents





child fatality review in texas

Child fatality review has grown rapidly in Texas. From one team that began in Dallas in 1992, there are now:

- 30 operating teams covering a population of 15,178,617 (77% of the state population)

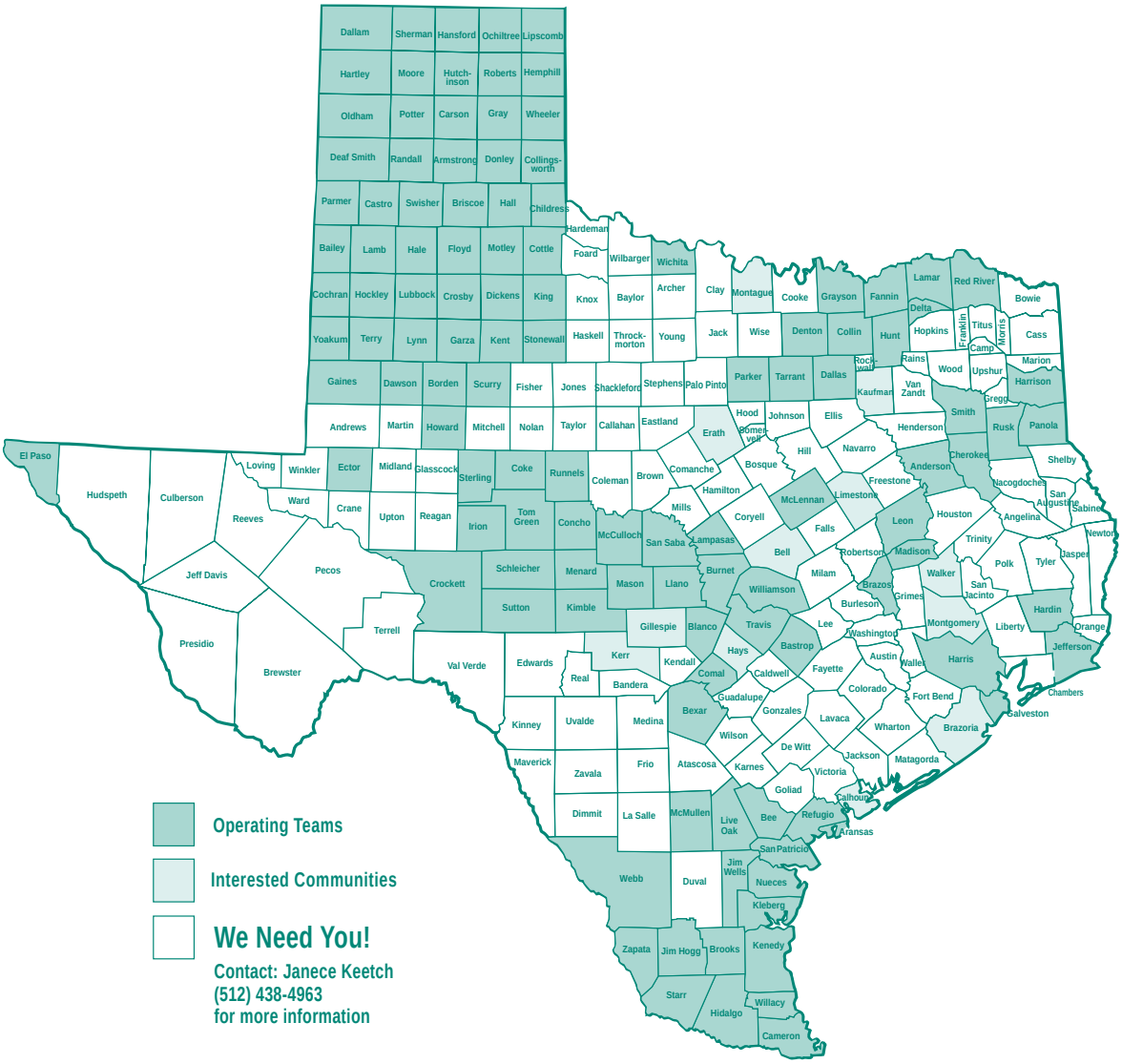
- 26 developing teams covering a population of 1,948,998 (10% of the state population)

Local communities have embraced the importance of child fatality review. Child fatality review teams are currently operating in 117 counties across the state. In an additional 36 counties, sheriffs, justices of the peace, and child protection staff are actively working to establish teams in their local communities. Individuals and agencies responding to situations involving a child's death have come to learn that working together results in a more coordinated response to these tragic situations. By formalizing their activities within the structure of a child fatality review team, members develop a clear understanding of the causes and incidence of child death, and the actions needed to reduce the number of deaths that are clearly preventable.

child fatality review teams

Counties Served

October 1998



natural causes

On the 4th of July, 1985 a beautiful little girl was born. The problem for little Angie, however, was that she was born 10 weeks prematurely, underweight and underdeveloped. Born to a drug addicted mother with a long history of substance abuse, Angie suffered from intraventricular hemorrhage and severe respiratory problems.

Angie lived with her mother for her first 6 months of life, until her mother's drug abuse made it impossible for her to properly care for Angie and her health needs. A paternal aunt took custody of Angie, but her medical condition soon worsened to the point where she could not eat and had to be tube-fed. She was hospitalized and soon thereafter, the aunt was informed that Angie's system was shutting down and she would not live much longer. Angie's breathing became increasingly difficult and she died 1 week later.

This story of Angie's life and death is not unlike that of many which occur each year. Natural deaths, those resulting from diseases, congenital anomalies, perinatal conditions, or certain ill-defined conditions, constitute the majority of child deaths. Nearly three-fourths of the natural deaths among children occur to infants less than 1 year of age.

More than 330,000 babies are born each year in Texas. About 2,000 of these babies die before reaching their first birthday and about 1,200 of them die before reaching one month of age. Congenital anomalies, Sudden Infant Death Syndrome (SIDS), and disorders relating to prematurity are the leading causes of death for these children. While it is difficult

to determine how many of these deaths are preventable, research has identified several preventative measures which can reduce the risk of child deaths from such causes.

Birth defects, primarily anomalies of the heart or of the respiratory system, result in the death of more than 500 infants annually. A not insignificant number of children also die from neural tube defects (NTD). Studies have demonstrated that the risk of NTDs can be reduced by as much as 70% with the daily inclusion of folic acid supplements prior to pregnancy or at early conception.

The rate of SIDS declined more rapidly during the 1990s than during the previous decade. This is at least partially attributable to the 1992 recommendation by the American Academy of Pediatrics to put healthy infants to sleep on their side or back. Even so, SIDS remains the second leading cause of infant mortality in Texas. This suggests that more can be done to prevent such deaths. Other preventative measures that have been shown to reduce the risk of SIDS include removing soft bedding materials from the infant's sleep area and reducing prenatal and postnatal exposure to cigarette smoke.

Each year more than 200 infants die from disorders related to short gestation. Although advances in neonatal technology over the past two decades have significantly improved the survival chances of low birthweight babies, it is at great expense. A recent Rand report estimates the cost to range from $60,000 to $275,000 for the first year of life.

Clearly it is in the best interests of the child, family, and society to prevent premature low birthweight babies or babies born with birth defects. Some relatively inexpensive maternal interventions, such as dietary supplements and regular prenatal care, can not only reduce the risk of infant mortality, but also the cost of health care. As more information about the causes and circumstances of infant deaths are gathered and shared, other means of prevention can be suggested.

motor vehicle crashes

After dinner at a nearby restaurant, mom, dad, and the 3 children, ages 5, 9, and 10, got into the family station wagon to return home. Jimmy, the youngest, was in the middle of the back seat with his older siblings on either side. The two older children buckled their seat belts, but Jimmy remained unbuckled. After all, it was only a short trip home.

No one could have predicted that a driver in another vehicle would run a stop sign and hit the station wagon in the right rear quarter panel. While the rest of the family received only minor injuries, Jimmy was thrown from the car. He suffered an open skull fracture and died at the scene.

A child dies in a motor vehicle crash, on average, every 15 hours in Texas. As such, this is the leading cause of injury fatalities for Texas children. The annual mortality rate due to motor vehicle crashes, after a steady decline during the 1980's, has remained relatively constant during the last decade. This indicates that further efforts must be made to prevent many of these needless deaths.

Motor vehicle fatalities can be greatly reduced with the proper installation and use of safety restraints. Research has demonstrated a 45 to 69% reduction in the risk of fatal injury when safety restraints are properly used. Efforts of the Safe Riders program within the Texas Department of Health and other educational efforts have been instrumental in increasing the proper use of child safety restraints. In addition to these efforts

and increased legislation there are also other ways of increasing use of safety belts. A study by the National Highway Traffic Safety Administration found that for each dollar level of fine for failure to use belts, states tend to realize about .08% increase in compliance. That is, an increase of $10 in the amount of the fine would tend to increase the rate of seat belt use by 8%.

1996 data from the Texas Department of Public Safety (DPS) reveals that 56% of the children who died in motor vehicle crashes were unrestrained. This translates into the prevention of more than 100 deaths if all the children had been in seat belts or infant seats.

Further examination of DPS data reveals more specifically how more child deaths can be prevented. Current Texas laws do not require children older than 4 years of age in the back seat of a vehicle to be properly restrained in a seat belt. Yet, in 1997 more than 80% of the children 4 years of age or older riding in the back seat who died in motor vehicle crashes were not restrained. Further efforts must be made to increase seat belt use and prevent deaths of Texas children.

homicide

A teenage female was found adjacent to a little-used roadway just off of a major freeway. She had been strangled with her own belt and a plastic bag. There was evidence suggestive of recent sexual activity. The case remained unsolved for several months.

At a child fatality review meeting, a team member from a local hospital (who had not been in attendance at the initial case review) heard me advising the team there had been no progress in the investigation of the case, and remarked that the decedent had been evaluated in the emergency room for a complaint of sexual assault just a couple of days prior to her death. She named her assailants during the exam.

This information was relayed to the appropriate homicide detective and a stagnant investigation evolved into the identification and arrest of two suspects who subsequently admitted to drugging the girl, having intercourse with her, and then killing her by strangulation.

The criminal cases were adjudicated recently. One youth received twenty years imprisonment while the other received ten years probation. Without the multi-agency input of information, this case would have most likely gone unsolved.

The tremendous increase in child homicide from 1987 to 1991 in which the rate more than doubled has been followed by an equally dramatic decrease during the last 6 years. Child homicide rates are now lower than during the early 1980's.

While this is certainly encouraging news, on average there is still a child murdered every other day in Texas.

Information available from death certificates demonstrates the demographic pattern of child homicides: male and female rates are comparable among all ages except teenagers, rates for minorities are 2 to 4 times higher than Anglo rates, the majority of all child homicide victims are 15 to 17 years of age, and 60% of the homicides are committed with a firearm.

Information collected and reported by local child fatality review teams indicates that a substantial number of child homicides are committed by children. One-third of the murders in which the age of the perpetrator is reported are committed by children less than 18 years of age. These child murderers are not killing children much younger than themselves. Victims of these children are almost always within a year or two of the same age as the perpetrator. Firearms are used in 75% of these cases. In contrast, the vast majority of the victims less than 5 years of age were murdered by an adult and less than half of these cases involved a firearm.

This information indicates that efforts to reduce children's access to firearms could help accelerate the decline in the number of child homicides.

firearms

In the middle of a summer night, a mother and boyfriend are sleeping when they hear a car drive up to their residence. They become anxious, and the woman goes to her closet to get a .25 caliber pistol. The car turns out to be someone simply using the driveway to turn around. The mother places the gun on the nightstand by her bed and returns to sleep.

Some time the next morning, the woman's 7 year old daughter goes into the bedroom, picks up the gun, and accidentally shoots herself in the chest. The mother and boyfriend rush the injured girl to the hospital, but the child dies less than an hour after the injury. Consequently, the mother is charged with a class "A" misdemeanor: "Making a firearm accessible to a child."

ach year more than 200 Texas children are killed with firearms, making guns the second leading cause of injury deaths among our children. Although the vast majority of firearm deaths are homicides or suicides, perhaps the most tragic are the unintentional shootings such as this case of the 7 year old girl.

Tragedies such as this one are compounded by the preventable nature of these deaths. Firearm education programs addressing the proper use and handling of firearms and safety education programs urging adults to keep firearms unloaded and locked away from the reach of children are de-

signed to decrease the number of unintentional firearm deaths.

Despite a jump in the rate in the last year, the rate of child deaths from unintentional gunshots has decreased 45% since 1991. Homicide firearm rates dropped more than 50% and suicide firearm rates dropped 25% during this same time.

Continued prevention efforts addressing proper storage and handling of firearms can help reduce firearm deaths among children, but technological advances which increase the safety of firearms should also be pursued. The lessons learned from child resistant bottle caps on medications and safety devices on lighters should be carried over to firearms. Devices which personalize handguns in which only the legal and rightful owner can discharge the gun are currently available. Encouraging firearm manufacturers to make this standard equipment for handguns would further decrease the number of children dying each year.

maltreatment

When our child fatality review team first began reviewing child deaths, death investigation protocols had not yet been written and joint investigation was not a standard procedure. So therefore, agency investigations were not as precise.

A review of the death of one particular child found no immediate cause of death and no evidence of foul play. This death was ruled SIDS by the medical examiner. There were a few questions, but the team accepted the death as a SIDS.

Two years later, a second child in the family was abused by the father. He received a ten year probated sentence for the abuse. The next year, a third child was abused. This time the police were wiser and cognizant of the first two children, one dead and one alive, but previously abused.

Upon questioning by the police, the father confessed that he smothered the first child because she would not quit crying. The first child's death once ruled SIDS is now re-opened for a homicide investigation and the case is taken to the Grand Jury.

The medical examiner submited a new death certificate. The team reviewed the death once again and is reminded of the value of the review process and the importance of a death scene investigation.

There are about 100 child deaths due to abuse or neglect reported to the Texas Department of Protective and Regulatory Services, Child Protective Services (CPS) in any given year. While this establishes maltreatment as one of the lead-

ing causes of preventable death among children, it has been suggested that this figure undercounts the actual number of maltreatment deaths occurring annually in Texas. In an effort to better understand how these deaths may be undercounted, the The Texas Department of Health and CPS recently completed a joint investigation into the misreporting of fatal child maltreatment.

Of the 396 fatal maltreatment cases recorded by CPS during FY 1992-1996, more than 35% did not have a corresponding cause of death recorded on the death certificate. The misreporting of many of these cases is understandable, however, in that neglect is difficult to code on a death certificate. For example, a child who dies in a house fire started from playing with matches while the mother was out drinking could be recorded by CPS as neglectful supervision. On a death certificate this may simply be certified as an accidental fire death.

More disconcerting, however, are the 15% of the fatal abuse cases which were certified on the death certificates as being due to some illness or other natural cause. These misreporting problems occurred most often when the certifier of death had not received all the information regarding the circumstances of death, or when a death was improperly certified by a physician. Misreporting of this latter type declined in 1995 and 1996.

Results of this study highlight the importance of child fatality review teams. As more information regarding the circumstances of death are shared, the nature and magnitude of deaths are more accurately determined.

suicide

Most of the children knew Jake and had seen him around. He was quiet and kept to himself, and did not have many friends. He kept out of trouble, and was well-liked by his teachers. But 14 year old Jake was having a private battle that no one knew about. His mother was an alcoholic. She was often verbally abusive towards him. Nothing he did ever seemed to please her.

One afternoon Jake and his mother had another argument. She wanted him to go with her to run errands, but he didn't want to go. A simple disagreement quickly turned into an ugly, hurtful yelling match. Jake stayed at home and after his mother left, went into her room and found a shotgun. He found the ammunition kept in another place. He took his own life.

Jake left a note with instructions regarding his funeral, apologizing for the pain he was causing. He placed the blame solely on his mother, stating he couldn't see an end to the pain he was forced to endure.

Since 1980 the death rate for Texas children has been declining for every cause of death except one: suicide. During the last 2 decades the suicide rate for children 10 to 17 years of age has increased more than 40%. More than 100 Texas children commit suicide each year; an average of 1 every 3 days.

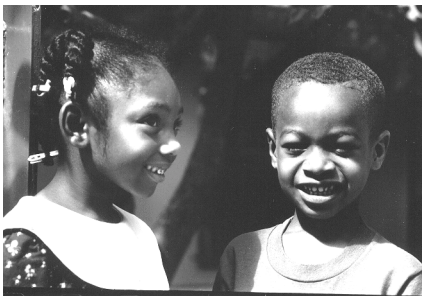
Many of the patterns evident in child suicide mirror those of older teens and adults. Males commit suicide 3 times more often than females, rates

for Anglos are 30% higher than for any other racial or ethnic group, and firearms are the most common method of committing suicide. Yet, while the firearm suicide rate has decreased in recent years, the rate of suicide by hanging has dramatically increased.

What can be done to prevent these needless and traumatic losses of life? Training for physicians and other adults in contact with adolescents on how to spot depressive and potentially suicidal behavior would help identify children in crisis. Expanded services for mental health and substance abuse treatment are necessary to help more children deal with factors that place them at higher risk of committing suicide. Coordinated efforts between families, schools, and community agencies can be effective in reducing many of the behaviors associated with suicidal risk.

recommendations

Recommendation:
Evaluate possible mechanisms to establish links between local CFR teams and established hospital-based neonatal review committees.
To move toward the truly comprehensive review of all child deaths, the efforts of established groups in the community can be accessed to augment the local Child Fatality Review Team's work. Neonatal deaths constitute a large percentage of child deaths and a portion of these are due to preventable causes. Currently, some efforts are duplicated unnecessarily and conversely, some deaths are not reviewed because they are assumed to have been not preventable. Establishing links between hospital-based committees and community-based teams will improve the comprehensiveness of the review of all deaths.



Recommendation:
Amend Chapter 673, Health and Safety Code, and Chapter 49, Code of Criminal Procedure, to clearly define Sudden Infant Death Syndrome (SIDS) in accordance with current standards of medical practice and establish improved protocol for reimbursement of autopsy costs for suspected SIDS cases.
Both statutes use different age groupings for SIDS which are inconsistent with current medical knowledge. SIDS may only occur in children under the age of one year. Additionally, with the development of local child fatality review teams and the mandatory requirement of autopsies of children in certain cases, confusion exists as to whether the Texas Department of Health can or will reimburse counties for these costs of autopsy. Failure to provide reimbursement may result in autopsies not being performed by qualified pathologists and procedures for proper death scene investigation not being followed.

Recommendation:

Laws regarding passenger restraint laws should be revised to include children 4 years of age and older regardless of position within the automobile.

Currently, passengers who are older than 4 years of age and seated in the rear seat of a moving vehicle are not required to use safety seats or restraints. The State Committee strongly recommends that the 76th Texas Legislature favorably consider and pass comprehensive legislation requiring all passengers under the age of 18 to be in age and size appropriate safety restraints, regardless of seating position or location in the vehicle. This legislation should also set out higher and consistent fines for failure to comply with the law.

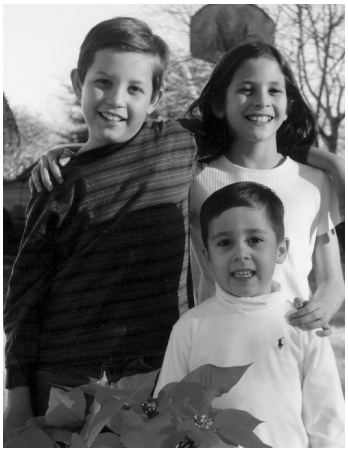
Recommendation:

Conduct an evaluation of the child fatality review team process in Texas.

Child fatality review teams have been in existence in some parts of the state since 1992 and there are now 30 operating teams reviewing approximately 40% of the child deaths occurring annually. As this multi-agency, cooperative process has developed in recent years, it is important to understand how, why, and in what context do teams make a difference in their communities. A thorough evaluation can identify barriers so that more deaths are reviewed each year, distinguish effective review team processes, and identify favorable outcomes of the review teams efforts.

Recommendation:

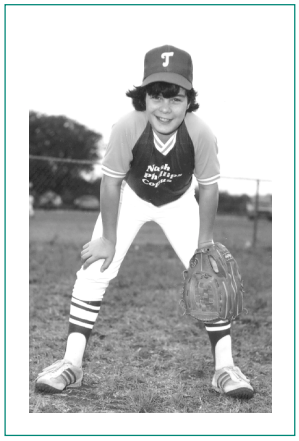
Develop, disseminate, and evaluate reference and training materials for CPS, Law Enforcement, Justices of the Peace, Medical Examiners, and EMS involved with child fatality response and investigation.



In 1998, the State Child Fatality Review Committee developed child death investigation guidelines and distributed them to Texas CPS, Law Enforcement, Justices of the Peace, and Medical Examiners. In keeping with this objective, the State Child Fatality Review Committee will continue to develop and distribute reference and training materials for these individuals, as well as evaluate the quality and effectiveness of the new materials.

past accomplishments

Through the efforts of the State Committee, the Children's Trust Fund Council of Texas, the Texas Department of Health, the Texas Department of Protective and Regulatory Services, and local child fatality review teams, the following has occurred:



Funding

- Executed 28 contracts with local teams for the purpose of team training and assistance (through funds appropriated to the Texas Department of Protective and Regulatory Services).
- Funded a part-time coordinator to assist the Harris County Child Fatality Review Team with data collection.
- Provided funding to the Hill Country, Tarrant, Travis, Wichita, Panhandle, South Plains, and Nueces teams to sponsor specialized training on child death investigation, review and data collection.
- Funded speakers at the Crimes Against Children conference held annually in Dallas.

Training

- Held two annual statewide training conferences for child fatality review team members and interested communities.
- Sponsored four regional trainings on child death investigations, review, and data collection.

Technical Assistance

- Developed and distributed the child death investigation guidelines manual for law enforcement, justices of the peace, medical examiners, and the Texas Department of Protective and Regulatory Services.

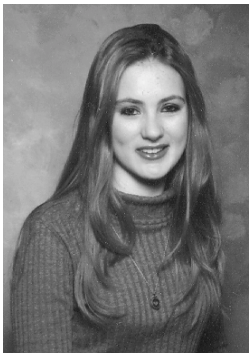
- Made presentations in Anderson, Nueces, Webb, Zapata, Smith, Limestone, and Tom Green Counties on starting a child fatality review team.

Public Awareness/Community Outreach

- Published "The TCFRT Lifeline," a quarterly newsletter that educates the public about why children are dying in Texas. This newsletter has a wide distribution and is an effective tool in the development of additional teams.
- Provided information on starting a child fatality review team to statewide audiences — Governor's Conference on the Prevention of Child Abuse, State Sheriff's Convention, Crimes Against Children Conference.
- Distributed information packets on starting a child fatality review team in response to more than 200 inquiries.

Local Team Accomplishments

- The **Bastrop County Team** began its review of cases in April 1997. Members of this newly formed team participate in annual child fatality review team network meetings.

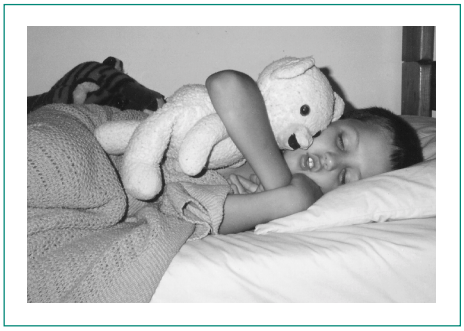


- The **Bexar County Team,** in operation since 1993, continues to meet monthly at the Alamo Children's Advocacy Center. Due to a number of drowning deaths in this area, prevention efforts focus on water safety.
- The **Brazos County Team** began operation in January 1996. Through joint review of child deaths, the team has been able to improve agency protocols for responding to situations involving a child's death. Team members are regular participants at the Crimes Against Children conference held annually in Dallas.
- The **Collin County Team** had its first meeting in early 1995, and reviews deaths occurring in Collin, Grayson, Fannin, Lamar, and Red River Counties.
- Based on the review of cases in **Comal County,** this team has learned that many fatalities are due to motor vehicle accidents caused by speeding, driving under the influence, not wearing seat belts, and not using car seats. The team has focused on public awareness campaigns promoting driving safety and preventing injury to children.
- The **Concho Valley Team**, comprised of 12 counties in west Texas, began development in 1997.
- Formed in 1992, the **Dallas County Infant Mortality and Child Death Review Team** was the first multi-agency review team of child death in the state of Texas. A forum is held every year to present re-

view team findings to the media and to the community. The report that is released helps violence and injury prevention organizations know where to focus their efforts. State Committee member Leslie Malone is a member of the Dallas County team.

- The **Ector County Team** has been meeting quarterly since April 1995. This team reviews approximately 100 deaths annually. Team members are working on procedures for improving coordination among agencies that investigate child deaths.
- The **El Paso County Team** reviewed its first death in May 1996, and continues to meet regularly.
- The **Galveston County Team** began reviewing deaths in October 1995. Prevention efforts include news releases and distribution of safety information at community events and at schools during child abuse prevention month.
- The **Hardin County Team** had its first meeting on October 30, 1997.
- The **Harris County Team** has been in operation since 1994. The team covers the most highly populated area in the state. In addition to Houston, there are 33 other cities or municipalities included in its boundaries. County Health, Hospital, Sheriff, District Attorney, and Medical Examiner Offices; Child Protective Services; and the City of Houston Health, Police, Fire, and EMS Departments are among the agencies regularly participating on the Harris County team. Team members are active in increasing knowledge of child fatality issues within their respective offices and the community. Team member Denise Oncken, assistant district attorney for Harris County and chief of the child abuse division, serves on the State Committee.

- The **Hill Country Team** has been reviewing child deaths since January 1995. In cooperation with the Hill Country Children's Advocacy Center, this team co-sponsored training entitled "Advanced Investigations for Child Abuse/Neglect." The training took place December 4-5, 1997, in Burnet.
- The **Hunt County Team** was organized in September 1997. This team worked with several local school districts to provide accident prevention and first aid training to fourth graders. This grade level was chosen because review team findings show that fourth graders tend to be the most seriously injured group in certain activities.
- The **Jefferson County Team** has been in existence since January 1996. With a focus on prevention, the team has identified severe prematurity as the predominate cause of child deaths over the last couple of years. In response, a prevention education project is planned to tar-



get mothers who abuse drug and alcohol during pregnancy. This team has also been instrumental in helping surrounding counties start teams.

- The **Leon/Madison County Team** began meeting in November 1997. Team members are regular participants at annual child fatality review team network meetings.
- The **Lower Rio Grande Valley Team**, covering Cameron, Willacy, Hidalgo, and Starr Counties, began meeting in October 1995. This team continues to meet on a monthly basis. Specialized training on conducting child death scene investigations has been provided to team members.
- The **McLennan County Team** began its review of deaths in October 1994. Team presiding officer Judge Cindy Evans has assisted in providing training to counties wishing to organize child fatality review teams; she is also a member of the State Committee. Waco Police Chief Gil Miller also sits on the State Committee.
- The **Nueces County Team,** in conjunction with Driscoll Children's Hospital, conducted the Fourth Annual Child Maltreatment Seminar on September 12-13, 1997, in Corpus Christi, Texas. Dr. Donna Rosenberg was the keynote speaker. This team's presiding officer, Paige Dinn, is a member of the State Committee.
- The **Panhandle Team** has been in operation since October 1993 and has 23 core team members. Two of its members, Dr. Rolf Habersang and TDPRS Regional Director Colleen McCall, are also members of the State Committee. This team addressed the issue of gun safety by developing a gun safety program and a PSA. The team also publicized ways to prevent deaths associated with unsafe cribs, riding in the back of pick-up trucks, and not using seat belts.
- Plans for forming a **Smith County Team** began in November 1997, when over 40 community members attended an organizational meeting. The team will begin their review of deaths in 1998.
- Started in 1994, the **South Plains Team** is based in Lubbock and encompasses 22 counties. One of the team's accomplishments is the development of a comprehensive checklist to assist physicians in the

examination of suspected victims of child abuse or neglect.

- The **Tarrant County Team,** which also includes Denton and Parker Counties, began reviewing deaths in September 1992. Team presiding officer Michael Floyd was instrumental in updating the child death investigation guidelines manual for law enforcement, justices of the peace, medical examiners, and the Texas Department of Protective and Regulatory Services. The Tarrant County Medical Examiner, Dr. Nizam Peerwani, is a member of the State Committee.
- The **Travis County Team** meets bi-monthly to review all child fatalities occurring in Travis County. In December 1997, the team issued its first annual report. Media attention generated by release of the report raised awareness within the community about why children are dying and what can be done to assist the Travis County team in addressing the problem.
- The **Tri-County Team** covers Harrison, Panola, and Rusk counties and is comprised of 17 members. The review team process has resulted in improved communication among those agencies responsible for conducting child death investigations. This team emphasized prevention by making presentations in local schools about water and firearm safety. Panola County Sheriff Jack Ellett is the team's presiding officer. Sheriff Ellett is also a member of the State Committee.
- The **Wichita County Team**, formed in May 1995, provided advanced child injury investigation training to team members. The team also sent law enforcement and child protective service staff to the annual Crimes Against Children conference in Dallas. For the past two years, the team has disseminated pamphlets about shaken baby syndrome to the community.
- The **Williamson County Team** sponsored a one-day training seminar on "Community Responses to SIDS." Captain Dan LeMay, Round Rock Police Department, and Dr. Linda Norton were featured speakers. Judy Hobbs, Justice of the Peace, Precinct Four, heads up the Williamson County team.

past recommendations

Included in the "Child Fatality Review Teams 1995 Annual Report" were several recommendations made by the state committee to improve the investigation of and response to child deaths. Each of these previously made recommendations is hereby addressed.

Recommendation:
Procedures should be strengthened between CPS and Law Enforcement to insure that child abuse cases are properly investigated by both agencies in a coordinated fashion. Those procedures should include joint investigative training.

The Tarrant County Junior College Criminal Justice Training Center in conjunction with the Professional Development Division of PRS are offering training to identified law enforcement academies and PRS trainers. The training will commence in January 1999 and will be completed for more than 3000 PRS staff by December 1999. Training will be delivered by a team of law enforcement and PRS trainers. This training, while required for PRS staff, is also being offered to law enforcement officials across the state.

Recommendation:
Explore the feasibility of establishing a tracking system for individuals involved in child abuse and child death.
The growth of child fatality review teams across Texas has resulted in greater coordination and communication among agencies involved in child death situations, thereby reducing the need for a computerized tracking system. Although there are isolated situations involving individuals who

are multiple perpetrators of child fatalities, it is believed that in most cases the network that is available to investigators through their local child fatality review team negates the need for a more formalized system.

Recommendation:
Develop automation for data entry by local review teams.
Using Centers for Disease Control and Prevention Epiinfo software, the Texas Department of Health created an automated system for collecting and analyzing local Texas Child Fatality Review teams data. The Texas Department of Health developed the Epiinfo programs with input from local review teams and provided the software to the teams free of charge. Currently, over half of the local child fatality review teams use the software.

Recommendation:
Revise the current CFRT field data collection form to facilitate collection of targeted information. Provide training to local teams on data collection.
In consultation with the Child Fatality Review state committee and members of local child fatality review teams, the CFRT data collection form was revised by the Texas Department of Health. The revisions are designed to provide more comprehensive information about particular circumstances of death and identify potential domains for prevention.

Recommendation:
The number of local registration districts (approximately 600) which support vital statistics registration, should be reduced.
The Bureau of Vital Statistics has continued to stress voluntary consolidation of local registration districts. The number of districts has reduced to 579 since 1995. Because consolidation is so difficult and has financial, operational, and political implications on local governments, the Bureau modified processes to facilitate the notification of deaths of children to local teams. This in turn, reduced the need for local child death review teams to obtain information concerning these deaths from local registration officials.

Recommendation:
Support widespread dissemination of the Shaken Baby Campaign and associated materials.
There have been twenty-six organizations funded by the Children's Trust Fund of Texas (CTF) that have implemented local education campaigns

and are working through collaborative community efforts to raise awareness about Shaken Baby Syndrome. These local campaigns include educational presentations and distribution of materials to children and adults in schools, hospitals, and prisons. Within the past two years, CTF has held successful training seminars for grantees, sponsored eight sites in Texas for a national videoconference, and presented workshops at the National Conference on Shaken Baby Syndrome. Currently CTF is collaborating with the Shaken Baby Alliance to assist in expanding campaign efforts. Comprehensive training with national speakers will be conducted in Dallas and Houston for medical, law enforcement, legal and prevention specialists.

resources

Alcohol and Drug Helpline
(800) 821 4357
A national hotline providing information about alcohol and drug abuse organizations in your area.

Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center
http://www.edc.org/HHD/csn/
The Children's Safety Network provides resources and technical assistance to maternal and child health agencies and other organizations seeking to reduce unintentional injuries and violence to children and adolescents. This site contains publications and resources, many of which can be obtained directly from this site.

Children's Trust Fund of Texas
http://www.ctf.state.tx.us/
CTF's mission is to prevent abuse and neglect of Texas children by leading the way in setting policy, offering resources for community-based prevention programs and providing information and education on child abuse and neglect. Visit this website for information about ongoing projects and initiatives.

Department of Transportation Auto Safety
http://www.nhtsa.dot.gov
Select "PEOPLE-Traffic Safety" for information on child passenger safety.

Harris County Child Fatality Review Team
http://www.hd.co.harris.tx.us/opa/child.htm
The Harris County Child Fatality Review Team, in operation since April 1994, meets on a monthly basis to review records and information pertaining to children whose deaths occur in Harris County. Due to the volume of cases - 729 child deaths occurred in Harris County in 1997 - deaths attributed to homicide, SIDS, suicide and accidents are given priority.

Injury Prevention and Control
http://www.tdh.state.tx.us/injury/
Injuries are the most under-recognized major public health problem facing the nation today. This site includes information and resources on how to prevent childhood injuries.

National Clearinghouse for Alcohol and Drug Information
http://www.health.org
Select “Resources and Referrals” to find out about prevention materials that can be ordered directly from the website and are many times free of charge.

National Inhalant Prevention Coalition
http://www.inhalants.org
Every year young persons in this country die of inhalant abuse. It can kill suddenly and it can kill those who sniff for the first time. Learn the warning signs.

SIDS Network
http://sids-network.org/
A world of information and support on sudden infant death syndrome and other infant death. The website is updated frequently so you are viewing the current information on these topics.

Texas Birth Defects Research Center
http://www.tdh.state.tx.us/epidemiology
Located within the Texas Department of Health, Bureau of Epidemiology. The mission is to identify and describe the patterns of birth defects in Texas, collaborate with others in finding causes of birth defects and means of prevention, and linking families with services.

Texas Child Fatality Review Team
http://www.tdh.state.tx.us/epidemiology/cfrt.html
This website, maintained by the Texas Department of Health, provides updates on the status of child fatality review in Texas. Visit this site to obtain detailed statistical information about causes and circumstances of child deaths, as well as the latest issue of the quarterly newsletter, conference information, and other related child fatality news.

Texas Department of Protective and Regulatory Services (TDPRS)
http://www.tdprs.state.tx.us/
TDPRS is charged with investigating reports of suspected child abuse and neglect. Visit this website for information about child protection in Texas.

Think Child Safety
http://www.1starnet.com/safety
"Think Child Safety" is a prevention program that utilizes community support to reduce injuries and deaths among children.

U.S. Consumer Product Safety Commission
http://www.cpsc.gov
Information on recalled items that present safety hazards to children.

To join a child fatality discussion list service sponsored by the ABA Center on Children and the Law
Send EMAIL message to: **listserver@mail.abanet.org**
In the body of your message type: subscribe child-fatal

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